

LETTERS TO THE EDITOR

Should training in colposcopy be obligatory in higher specialist training in genitourinary medicine?

Several papers¹⁻³ have highlighted the important role of colposcopy in genitourinary medicine (GUM). A recent survey⁴ shows that 32% of GUM clinics provide a diagnostic colposcopy service with over 50% of these clinics additionally providing outpatient treatment facilities for varying degrees of cervical intraepithelial neoplasia (CIN) confirming that colposcopy is established as an integral part of GUM clinic practice. It is therefore expedient for us to consider colposcopy training as obligatory for higher medical training in GUM to achieve the standards expected of a competent colposcopist^{5,6} and to consider a programme of training to achieve this.

It is our belief that colposcopy services within GUM should aim to provide both diagnostic and outpatient treatment modalities of the highest standard with close links between cytology, histopathology and gynaecology. We believe that the programme outlined below would provide adequate training in colposcopy to achieve this and that the Specialist Advisory Committee (SAC) in GUM should consider incorporating this or a similar programme as a Higher Specialist Training Requirement for Accreditation in GUM.

Proposed programme for colposcopy training in genitourinary medicine

The trainee should hold a post in GUM approved by the Joint Committee on Higher Medical Training (JCHMT).

Prior to this colposcopy training, those trainees without Membership of the Royal College of Obstetricians and Gynaecologists should have completed training in gynaecology as experience in clinical gynaecology is essential in cases where co-existing gynaecological pathology may complicate management strategy. It is, therefore, essential that the trainee completes six months in a Joint Committee on Higher Medical Training approved gynaecology post or attachment prior to commencing the training programme in colposcopy.

The training period in colposcopy should be six months with at least one session per week with an Approved Trainer. This should include both diagnostic colposcopy and exposure to the various outpatient treatment modalities. During this period it is essential that the trainee attend three sessions with a

cytologist/histopathologist and complete an approved educational course on basic colposcopy.

The Approved Trainer should be a consultant genitourinary physician or a consultant gynaecologist with at least 2 years experience of providing a regular colposcopy clinic, preferably with treatment facilities for CIN and should see at least 3 new patients per clinic. The training should be under consultant supervision. Effort should be made to expose the trainee to advanced cervical pathology, that is, microinvasion and cervix cancer and attendance at the local gynaecological oncology unit may be desirable.

A separate certification is not required but it must be left to the supervising consultant(s) of the JCHMT approved post in GUM to ensure that this training is provided and to make available the details of the training programme to the SAC for approval.

We sincerely hope that due consideration will be given to this letter and appropriate steps taken to implement a programme of training with the prime aim of providing a high standard of colposcopy service within GUM in keeping with the high standard we presently provide in the management of other STDs and related conditions and additionally, to allay the fears of those gynaecologists who are concerned that the standard of colposcopy in GUM may not be up to expectation.

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HIV infection in Tirupati, India

The AIDS and HIV infection appears to be a truly new condition in each of the populations it has affected and is a highly lethal epidemic that was first reported in May, 1981.¹ In India by April 1986 the existence of HIV infection and AIDS was established, which heralded serosurveillance of high risk

group individuals for the prevalence of HIV infection through a network of surveillance centres.² As a part of such a surveillance programme 7050 high risk group individuals, namely 4957 STD clinic patients (3594 males and 1363 females, 1195 blood donors (1144 males and 51 females), 54 female prostitutes, 820 antenatal cases and 24 contacts of HIV infected cases, were screened to find the prevalence of HIV infection at Tirupati, a renowned Hindu pilgrim town in South India which is about 150 km from Madras and Vellore where a high prevalence of HIV infection has been reported.²

Serum samples were collected from these individuals and tested for the presence of HIV antibodies by ELISA using Wellcozyme brand kits. Repeatedly ELISA positive sera were subjected to a confirmatory Western Blot Test.

Out of 7050 samples screened, 50 were seropositive (0.71%). Among 3594 male STD patients, 31 (0.86%) were seropositive. However, among 1363 female STD patients who were either contacts or wives of male STD patients no HIV seropositivity was detected. In contrast to this, a high prevalence of HIV infection was found among 14 (25.92%) of 54 female prostitutes tested, which reinforces the belief that the risk of acquiring HIV infection is greater in persons having a large number of sexual partners.³ Out of 1144 male blood donors three (0.26%) were seropositive and among 51 female blood donors seropositivity was not noticed. Among 820 antenatal cases tested 2 (0.24%) were positive. None of the regular contacts or spouses of 50 HIV seropositive individuals were seropositive, thereby indicating seropositivity need not be associated with infectivity.⁴ The incidence of HIV seropositivity among high risk group individuals screened in different parts of India varies greatly from 0.03% to 0.54%.⁵ Factors like life style, nutritional status, nature of infectious co-factors and differences in the genetic make up may be responsible for such variations.⁶

Globally now there are several ongoing studies to define the spectrum of seropositive cases both in rural and urban areas. HIV infection and AIDS cannot be controlled anywhere if efforts are not made everywhere. There is hope that the future will permit control and cure if not eradication of HIV infection.

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Endemic syphilis in Bulgaria

Between 1958 and 1962 an eradication campaign against endemic syphilis, using 10 to 15 days course of injectable penicillin, was carried out in Bulgaria. The subjects were predominantly of Moslem Turkish origin. In all 608,816 persons were examined and serological tests for syphilis performed. Of these persons 6,290 (1.0%) were found to have endemic syphilis.

To see if the previous campaign had been successful, a further study was made between October 1989 and March 1990 on 27,435 Bulgarian Moslems of the same background as the group of 1958-1962. A total of 23 persons were found to have positive serological results of whom four were due to primary, secondary or early latent syphilis, leaving 19 (0.07%) of 27,435 who were thought to have endemic syphilis.

The frequency of endemic syphilis had diminished to one fifteenth of that in 1958-1962. The mean age of those with endemic syphilis was 56.3 years, 11 were men, eight were women. All were country dwellers with limited education. It is possible that some persons with endemic syphilis have died since the previous survey or emigrated to Turkey.

The conclusion is that endemic syphilis is more or less eradicated in Bulgaria. There may be factors in its disappearance other than medical intervention, such as a general increase in living standards.

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Incidence of *Neisseria gonorrhoeae* and *Chlamydia trachomatis* infections in Strasbourg over 8 years

As described in many western countries, the incidence of sexually transmitted diseases (STD) has been decreasing since 1980 and this phenomenon is assumed to be related chiefly to the emergence of HIV infections.¹